A COMMON PAINFUL AFFECTION OF THE FEET: THE INGROWING TOE NAIL.

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To the sum total of painful, incapacitating ailments which it falls to us to treat, and which fortunately we can do so with assurance of relief and usually of cure, those arising from ingrowing toe nails, flat feet, hallux rigidus and valgus form quite an appreciable percentage.

Although these conditions are common, especially with the present-day fashion of smart, but not always suitable footwear, of "hiking" crazes, frequently undertaken with impractical equipment, and of cheap transport, discouraging the development of good leg and foot muscles, the prompt recognition and adequate treatment of painful feet is not always the rule. I often see patients who have been treated for quite appreciable periods, having had ineffective applications of iodine, Scott's dressing, baths and liniments to their feet; many of them having been to chiropodists, masseurs and physio-therapeutic departments, some to rheumatic clinics, and a few even to the light clinics.

The Ingrowing Toe Nail.—It is usually the great toe nail which is affected and it is predisposed to by unsuitable, tight footwear and indifferent toilet of the nail; an accident to the toe, too vigorous manicuring, or a painful flat foot exciting it into an acute condition. Before medical advice is sought, linseed, bread and soap poultices, oils, baths, &c., have been practised at home, following the directions of the first-aid books, ambulance man, local "sage," or occasionally of the chemist. These measures convert it into a subacute condition with the surrounding area devitalized.

The nail and the toe are sodden and swollen, the nail sides are obscured by pale, red exuberant granulations, purulent epithelial debris which has swollen over from the nail folds, and thin serous pus exudes from beneath it. Thorough clipping of the corners of the ingrowing nail has recently been practised with a pair of sharp-pointed scissors. It will readily be appreciated that each time these are used, almost invariably unsterilized, the sharp points will lacerate the delicate, oedematous tissues of the nail bed and sides, and they will carry infection in from the exterior.

A vicious circle occurs, the cut corners stimulate rapid growth at the nail edges, the regular clippings carry in infection and lacerate the nail bed, and frequent soakings in baths and poultices make the skin sodden and swollen, preventing easy exit to discharges and inhibiting healing. The condition progresses until the patient is incapacitated by pain, and the infection becomes acute; occasionally a "whitlow-like" condition supervenes in the toe.

The average treatment consists in packing around the nail with cotton wool, and this is effective in mild cases, but it is not adequate when the condition is well established.

Should the sufferer be sent to hospital, frequently one of the operations described in the surgery tomes will be performed by a house surgeon; he will remove all or part of the nail, or he may remove half the nail bed, or some of the soft parts of the toe. The results vary, but incapacitation for some time is constant and dressings are needed for lengthy periods.

The textbooks are generally brief on the all-important details of the toilet of the foot, although quite full on the steps of operative procedure. I have not operated for this condition for nine years, and I hope the occasion to do so will not arise. Even advanced cases will respond to the following homely and simple treatment faithfully carried out. The basis of it was explained

to me when I suffered from this complaint twenty-five years ago, by a layman who had a good store of that uncommon sense, "common sense." I have developed it in the light of surgical principles.

The essence of it is "to leave the nail alone."

(1) Poultices, liniments and soakings in baths must stop. A rapid daily wash of the feet is sufficient.

(2) With the tip of a match-stalk the granulations round the nail should be gently and sparingly touched with iodine daily. Free applications "pickle" and harden the tissues and are unnecessary.

(3) All manicuring of the under surface of the nail and its folds must be discontinued.

Diagram showing (a) Method of cutting the nail ; (b) The shaded area shows the surface which is scraped with the scissor blades ; (c) Note the corners are allowed to grow beyond the toe end, and then cut.

(4) The cutting of the nail.—Patients are instructed to procure a round-ended pair of surgical scissors. These will not lacerate the granulations or do much damage if they slip. Instead of stimulating the nail growth at the sides by clipping off the corners, growth is hastened at the nail-centre in two ways :—

(a) By cutting a shallow V or U in its centre.

(b) By scraping the middle of the surface of the nail with the scissor-blade, as per diagram. This may also have the effect of slowing growth at the sides of the nail.

The patient, his relatives, or the casualty or visiting nurse are instructed to carry out this clipping twice a week.

The nail corners are ignored, as per diagram, until they project beyond the end of the toe, when they are then cautiously levelled off.

(5) *The Dressing*.—A small piece of aseptic gauze is applied at hospital, and patients are instructed to procure a supply of this ; on a piece of clean, soft old linen, held before the fire until it is singed brown, is lightly wrapped round the toe. No pads, &c., are advised ; a bulky dressing prevents the shoe being pulled on and the patient working.

(6) A thick pair of socks or stockings must be worn, and these should be changed frequently.

(7) A pair of stout shoes or boots, of adequate fit at the toes, must be procured. The modern pointed shoe tends to press the nail sides into the underlying skin, chafing it and predisposing to infection and an ulcer.

The results of this treatment are gratifying alike to patient and doctor. It enforces cleanliness and gives nature a chance to repair the damage.

The relief occurs in a few days and work can be resumed. Complete healing may take from four to six weeks, according to the care taken by the patient.

It is remarkable how the most exuberant granulations slowly recede and shrivel down into a protective scab which separates several weeks later, leaving a healed surface. A repulsive, oedematous smelling toe becomes quite "respectable" and able to do a week's work without any protest. Occasionally, the entire nail separates. The policy of leaving it alone is followed ; I have seen one take three months before it separated, leaving a perfect new nail, almost grown, beneath.

The following is a copy of the instructions I give to these patients, and as a rule they only report once after the first consultation. Special inquiries elicited that their silence "gave consent" to the conclusion that all was well with the toe.

INSTRUCTIONS GIVEN TO PATIENTS.

CARE OF INGROWING TOE NAILS.

Cut a V in the middle of nail twice a week, with round-ended scissors. Never use pointed scissors; these are harmful to the nail.

Scrape the surface of the middle of nail with the scissors blades twice weekly. This stimulates growth here and slows it at the sides where the ingrowing is taking place. Wash feet daily quickly; do not soak in a bath.

Apply a *very little* iodine daily to the sore spot with the end of a match and also apply a small clean dressing. Avoid all cleansing of the sides and under part of the nail and on no account cut off the corners until they project beyond the end of the toe.

Wear a stout-soled shoe or boot which fits comfortably, and also a thicker sock or stocking than usual. These socks should be changed every other day or worn alternately with another pair.

A word of warning may not be out of place here with regard to very chronic ulcers or sores about the hallux, and even about the foot. Occasionally they follow a wound and may be in the middle of a callosity. I have seen two about the toe nail, thus justifying the inclusion of this paragraph in this article.

It is always sound practice to examine the pupils, the knee-jerks and reflexes to exclude a possible underlying nervous disease. A still rarer condition, of which I have seen two cases in the past eighteen months, is that of spina bifida; and in both inspection of the patient's back revealed a tuft of hair on a fatty pad in the lumbar region and suggested, whilst X-ray confirmed, the diagnosis of spina bifida occulta.

A thorough cleansing of the lesion, careful

B.I.P.P. application to the wound, good padding and a stout plaster of Paris casing will bring about healing. The B.I.P.P. prevents the smell which usually occurs when plaster is applied over a wound.

CLINICAL NOTES ON THREE CASES OF PURPURA HÆMORRHAGICA.

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THE first case was a man, aged 21, and the history of his illness was as follows: He was quite well until five days before admission to hospital. The first symptom was profuse bleeding from the rectum. Two days later he noticed "red spots" on his face, and the urine was dark in colour. On admission, patient was unconscious. Petechiæ were present on the face and limbs. His temperature was subnormal but went up to 101.5° F. before death. His breathing was stertorous, and he was incontinent of urine which contained much blood. The knee- and ankle-jerks were not obtained. Lumbar puncture produced a hæmorrhagic fluid. The patient died twelve hours after admission. Permission to do a post-mortem examination was not granted, so that it is impossible to state the origin of the blood in the cerebro-spinal fluid.

The second case was a man, aged 20, and the history was as follows: He was quite well until three days before being admitted to hospital. The first symptom was hæmatemesis associated with abdominal pain, and his doctor suspected an acute gastric ulcer as being the cause. On examination, numerous petechiæ were present in the region of the elbows and knees. Both the tonsils were enlarged and unhealthy. There was some tenderness in the epigastrium,